A Public Health Approach to Mitigating the Negative Consequences of Illicit Drug Abuse

NATIONAL ASSOCIATION
FOR PUBLIC HEALTH POLICY

I. INTRODUCTION

DRUG abuse continues to be a significant public health problem of our era. A century of increasing criminal justice efforts culminating with the "War on Drugs" has produced few positive outcomes and many negative sequelae. Illicit drugs are just as widely available now as prior to this "War" (1). And more importantly, there are millions of drug abusers and their families who are experiencing difficulties because of illicit drug abuse.

It is time for a paradigm shift in conceptualizing public concerns regarding individual drug-related human behavior. Concern for individual and family functioning which promotes the public's health should be our primary focus. A harm reduction approach, which is a policy of preventing the potential harms related to drug consumption rather than trying to prevent drug use itself, meets these criteria. Inherent in this policy is respect for individuals' civil liberty and their right to the pursuit of happiness.

The National Association for Public Health Policy acknowledges that today's largest drug problems relate to the mostly licit drugs —alcohol and tobacco. A rational, comprehensive policy would, in the ideal, address all psychoactive drugs in a consistent manner. However, due to the legal differences in how society deals with and responds to these categories of drug consumption, this statement will focus on the predominantly, and currently, illicit psychoactive drugs. It is believed that the following perspective is grounded in objective reality. It is a policy of compassion and understanding, with the ultimate aim of improving the human condition.

II. STATEMENT OF THE PROBLEM

A. Extent of Problems with the Currently Illicit Drugs

In 1995, approximately 22.7 million Americans had used an illicit drug at least once (2). The lifetime prevalence of illicit drug use is 30.68%. The lifetime prevalence of drug abuse/dependence syndromes is 6.19%. Of those individuals classified as regular users (i.e., not experimental users), roughly 20% qualify as current or former cases of drug abuse/dependence (3). It has been estimated that about five million people are currently in need of treatment for drug abuse, of whom less than one-fourth are actually receiving this therapy. In 1989, there were an estimated 10,710 deaths directly resulting from drug consumption, and another 7,703 drug-associated deaths (4).

The total economic costs of illicit drug abuse were estimated to be $66.9 billion in 1991. Of these, $3.2 billion went for direct medical costs for drug abuse. An estimated $46 billion was spent on other related costs: (a) Direct—crime, motor vehicle crashes, etc., (b) Indirect—victims of crime, incarceration, etc., and (c) Special Conditions—IDU-attributable AIDS, etc. (4).

B. Failure to Distinguish Drug Abuse from Drug Use

Classifying all illicit drug consumption as drug abuse is invalid. Current laws and strategies reflect more of a value judgment of the drug in question than an objective evaluation of the drug-taking behavior or its likely consequences. All of the currently illicit drugs can be used and abused—abuse being defined as taking drugs under circumstances and at doses that significantly increase their hazard or impair the ability of individuals to adequately function or cope with their environment (5,35). Drug abuse is a maladaptive pattern of substance consumption manifested by recurrent and significant consequences related to the repeated use of drugs (6). It is these behaviors that drug policy should focus on with education, prevention, and treatment strategies.

It is clear that most persons who take illicit drugs are experimental or social-recreational users (35). The Epidemiologic Catchment Area Study, for instance, found that only one out of every five persons who used illicit drugs had ever met diagnostic criteria for drug abuse or dependence (3). The typical drug user is scarcely distinguishable from the typical citizen, and most were introduced to illicit drugs by a close

friend, not a pusher. It is ironic that the U.S. government has documented the widespread prevalence of drug use rather than abuse (7, 3,2). Only in the past few years has the Substance Abuse and Mental Health Services Administration initiated a nationwide project of state needs assessments aimed at identifying numbers of substance abusers, rather than users, in each state, as a basis for planning prevention and treatment services. Yet, this same government advocates a policy (viz., the War on Drugs) which treats all illicit use as abuse. This is a major cause for the failure of the Drug War and prohibitionistic policies in general.

C. Negative Outcomes of the War on Drugs

1. Increased Transmission of HIV and the Societal Burden of AIDS. It is unfortunate that current policies to reduce drug consumption have increased the burden of HIV/AIDS on society. The emphasis on law enforcement has increased the spread of AIDS in numerous ways. The criminalization of drug sales and trafficking has dramatically driven up the cost of the currently illicit drugs in comparison to their cost of production, or as compared with alcohol and tobacco prices. This increased cost permits the inflated profits earned by traffickers engaged in a very high risk, illegal business. Unable to support their dependencies via legal jobs, some abusers turn to crime and prostitution. Large numbers of IDU prostitutes, and their customers, have contributed to the spread of HIV via unsafe sexual practices.

Injection drug users (IDUs) also transmit HIV via contaminated syringes. Of all AIDS cases in the United States to date, roughly 25% involved injection drug use as the sole exposure route, and 6% have occurred among men who have sex with men who also report injection drug use (8). Recent trends suggest that a majority of new HIV infections in the U.S. are due to injection drug use or to sexual contact with IDUs (9). The primary reason for these problems is the limited access to sterile hypodermic syringes and needles in America. Tens of thousands of IDUs have contracted HIV as the result of the unavailability of sterile syringes. This, despite the fact that research to date has demonstrated that Needle Exchange Programs (NEPs) substantially reduce HIV transmission without increasing drug consumption. Organizations which support NEPs include, but are not limited to, the World Health Organization, the American Medical Association, the National Academy of Sciences, the National Insti-

tutes of Health, the American Public Health Association, and the Centers for Disease Control and Prevention. But when the Clinton administration finally issued a finding that NEPs were effective in preventing AIDS and did not promote drug abuse, they also decided not to permit federal funds to be used in support of such programs lest the "wrong message" be conveyed—that any illicit drug use can be tolerated, even in order to save lives.

There is scientific and anecdotal evidence that medicinal marijuana can help individuals with AIDS Wasting Syndrome and other health problems without serious side effects (10). The recent passage of ballot initiatives in California and Arizona have highlighted public concern over the need for adequate care for such patients. The federal government's unwillingness to allow the legal medical use of marijuana is a direct affront to the U.S. public's health.

2. *Racism.* The War on Drugs' disproportionate burden of people of color is one of the more pernicious aspects of the drug prohibition movement. As Jonas (11) states:

> The "Drug War" is no more about drugs than rape is about sex. Both are about violence and control . . . the "Drug War" itself has little impact on drug use. . . . The goals of the "Drug War" are concerned rather with the control of those ethnic minorities at which it is aimed. (p. 19)

The majority of drug consumers in the United States are, in fact, white (2,12), but the majority of persons in prison or jail for drug-related offenses are non-white (12,13,14). In 1994 nearly 7% of African-American men were behind bars, compared with less than 1% of white males. The majority of the increasing incarceration rates among African-American males are for drug law violations, trends in arrests and prosecution, and sentencing requirements (15).

The development of mandatory minimum sentences has increased the incarceration rate for drug offenders. This measure also falls disproportionately more on African-Americans. Sentences for cocaine and crack cocaine illustrate this bias. There is no pharmacological difference between cocaine and cocaine freed from its base (i.e., crack). In U.S. federal courts, 27% of powder cocaine defendants were African-American and 88% of crack cocaine defendants were African-American. Conviction in federal court for possessing 5 grams of crack cocaine results in a 5-year minimum sentence, while

it takes 500 grams of powder cocaine to receive this same sentence (15).

It is a sad comment on our society that more young black males are incarcerated or on parole/probation than are attending college (13). In fact, at current levels of incarceration, newborn black males in this country have a greater than 1 in 4 chance of going to prison during their lifetimes, compared to 1 in 6 for Hispanic males, and 1 in 23 for white males (14). New approaches are needed to heal racial divides, not widen them as recent drug strategies have.

3. *Ineffective Drug Education.* Prohibitionists' unwillingness to accept the realities of drug-taking behavior have led to largely ineffectual drug education programs. Drugs must be portrayed in ways that justify their absolute prohibition and there must be no hint of positive effects or of users who remain unharmed. Use of scare tactics, in one form or another, has characterized most drug education programs in the schools and the mass media. From Reefer Madness in the 1930s to the Egg in the Frying Pan in the 1990s, these approaches are dishonest and inflammatory. The most widely used drug education curriculum in the country is Drug Abuse Resistance Education (Project DARE). This curriculum is utilized in about 70 percent of the nation's fifth-grade classrooms, despite the substantial body of evidence indicating that the program has little if any impact on reducing drug use or abuse over the long term (16,17,18). Ignoring the growing number of negative evaluation studies, the United States government and national organizations like PRIDE vigorously endorse this curriculum.

Most current school and media programs are critically flawed. These programs are not contributing to the health of American children. Limited funding should be re-targeted to more promising and innovative approaches. Model curricula do exist which have been shown to actually have some impact on reducing drug abuse, at least in the short term, especially the most dangerous but not illicit drug—tobacco. Aside from little or no use of scare tactics, these programs are typified by a broader health education approach, not merely drug education; they involve students as active participants rather than passive recipients; and they focus more on teaching skills rather than on teaching facts or imparting values.

4. *Limited Drug-Abuse Treatment Funding and Interventions.* An estimated five million Americans are in need of treatment for drug

abuse. Overall, less than one-fourth of those needing treatment get it (19). Evidence also indicates that treatment is more cost-effective than law-enforcement and interdiction (20). Treatment approaches in America have also been limited in the modalities used. Abstinence-based models predominate despite evidence that these approaches do not meet the needs of many abusers. Other countries are experiencing success with greater use of methadone maintenance, private physician-based methadone maintenance, and heroin maintenance. Also, needle exchange programs are channeling IDUs into treatment programs.

Drug treatment in the United States is thus not fulfilling its potential for reducing drug abuse. This is unacceptable, given the many billions of dollars wasted on ineffective supply-reduction strategies and the inadequate use of the aforementioned treatment approaches.

5. Corruption. The illicit drug trade is one of the largest industries in the world. Its net profits range from $400–$500 billion a year, and it represents 8% of all trade (21,22). Cocaine is now the most profitable single item of trade on the planet (23). This huge amount of cash, and the inability of government efforts to have any significant impact on this market, creates a cynical police attitude. It is an environment which invites and encourages corruption.

Corruption occurs at all government levels and in the private sector (e.g., money laundering in banks), both in and outside the United States. Police, immigration officers, lawyers, etc., are all vulnerable to drug money. Recently, the Mexican general in charge of his country's drug war was arrested for receiving payoffs from the drug cartels (24). Barry McCaffrey, America's drug czar, argues that drug trafficking threatens the democratic core of Mexico (25). Similar situations exist throughout Central and South America and Asia. In these regions drugs are an important source of income and employment, bringing billions of dollars each year and providing wages for hundreds of thousands of workers (26).

Current supply-reduction efforts are failing much as alcohol prohibition did earlier in this century. That prohibition helped create organized crime as we know it today, and created widespread corruption within law enforcement, the courts, and political office holders. By 1929, one out of every four federal prohibition agents had been dismissed for charges ranging from accepting bribes and extortion to drinking the evidence (42). Bootleggers in Detroit paid out an

estimated two million dollars per week to police and public officials who turned a blind eye to openly operated breweries and saloons (43). Today, it is estimated that more than half of all organized crime revenues come from the drug trade (26), and those revenues continue as a powerful corrupting force. At the same time, policing a victimless crime compels police to adopt tactics which are corrupting in themselves. The current system thus encourages criminal behavior, damages the criminal justice system, and causes harm to the public's health.

6. Supply Reduction and Violent Crime. Research does not support a simple connection between drug consumption and violence or other criminal behavior, as current policy makers assume (27,28,29). A substantial proportion of drug offenders do not commit property or violent crimes. While the artificially high cost of illicit drugs drives many addicts to criminal activity as a way to support their habit, most consumers of illicit drugs do not rely on predatory crime to support their drug use (30).

The above, however, is not true of drug traffickers. The illegal drug market provides its greatest opportunities to violence-prone, criminally minded individuals. The illegality of the market means that adversaries have no legal mechanisms for handling disputes (31). Kennedy (32) notes that when law enforcement cracks down on drug markets, dealers move into other areas, thereby causing turf battles. Drug users and traffickers also make tempting targets for violent thefts because they possess large amounts of cash and are much less likely to report their victimization to police (31). And, much of the urban murder rate can be attributed to drug dealers killing each other (33,34).

Supply-reduction efforts have made the cure worse than the disease. It would seem that more finely targeted strategies are needed for dealing with the small portion of abusers who do commit violent offenses to obtain drugs or as a result of their use. The current law-enforcement supply-reduction strategies thus need serious re-thinking.

7. Inadequate management of pain. Since passage of the Harrison Act, federal agencies charged with enforcing the drug prohibitions have carried on a campaign of terrorizing physicians who might prescribe narcotics to the "wrong" patients or in too large a dose. Even after the Supreme Court decided in the case of *Lindner vs. U.S.* that physicians could not be prosecuted under the Harrison Act for

prescribing for addicts, the Federal Narcotics Bureau went right on arresting doctors for doing so, simply taking the precaution of never bringing them to trial where they could be acquitted (44).

In 1996, the license to practice medicine of more than 120 physicians who were prescribing narcotics for chronic-pain patients was revoked or suspended. Chronic-pain patients, by definition, need long-term pain relief and commonly need increased dosage as their condition worsens. But prescribing narcotics for more than a few months or increasing a narcotic dose can place a physician's career in jeopardy. As a result, a vast number of chronic-pain patients suffer unnecessary pain and disability.

One narcotic, widely used in some other nations, has been declared legally to have no medicinal value. Although heroin obviously has the same medicinal value as morphine, since heroin is converted into morphine once it is in the human body, and differs only in having a swifter onset of effects, this bureaucratic decision makes heroin unavailable for use with patients for whom swift relief of pain is indicated. An identical bureaucratic decision rules that marijuana has no medical use, despite a 2,000-year history of such use. In this case the ruling stands against both a large body of anecdotal evidence claiming relief from nausea, muscle spasms, pain, AIDS wasting syndrome, and glaucoma, and FDA-approved clinical trials of smoked marijuana as an anti-nauseant in conjunction with cancer chemotherapy. Oddly, despite its demonic reputation, cocaine has always remained available for medical use.

III. PURPOSE AND OBJECTIVES

The purpose of this policy statement is to provide a foundation for public health to provide leadership in preventing and treating America's illicit drug problems. This statement also provides a basis for mitigating the disastrous consequence of the "War on Drugs."

A. Attention to Social Antecedents of Drug Abuse

Drug abuse is interwoven with the problems of poverty, illiteracy, family disruption, racism, inequalities of opportunity and economic status, mental illness, and the maldistribution of political power and authority. Solutions will require consideration of social, economic, political, and cultural environments.

B. Focus on Education, Prevention, and Treatment

The promotion of healthy lifestyles and the prevention and treatment of drug abuse should receive top priority. Successful public health approaches to dealing with alcohol and tobacco abuse can be applied to illicit drugs. Punitive legal measures should be tightly refined and of secondary importance in practice and resource allocation.

C. Holistic Approach Toward Drug Issues

The focus of drug policy should be people, not drugs. Over the last 10,000 years people have used psychoactive substances in attempts to treat illness, achieve oneness with a supreme being, elevate consciousness, relieve anxiety, and share pleasurable experiences with others. Current programs too often: (a) focus on the drug rather than the human-drug interaction, (b) emphasize drug effects rather than the drug-taking behavior and its determinants, (c) fail to put current issues into historical perspective, and (d) offer simple solutions to complex problems.

To the extent that certain individuals have created more problems for themselves than they have resolved through their consumption of drugs, it is the responsibility of society to address these issues. An understanding of the integration of drugs and individuals into human communities and the ecosystem is essential (35).

D. Emphasis on Evaluation and Research

Research and evaluation efforts must be rigorous and unfettered by the "Drug War" mentality. Alternatives to limited, abstinence-based education and treatment in a prohibitionistic framework need to be explored. Harm reduction efforts in Europe and Australia offer useful examples (44,45).

Value judgments about certain drugs, and the segments of our society who consume them, should no longer be a basis for policy. Approaches to drug issues should be based on documented success at increasing healthy functioning and reducing maladaptive behavior. The current state of our knowledge in this area is inadequate. Greater support for research, and redirection of current priorities, is thus warranted.

E. Deemphasis of Legal-System, Supply-Reduction Efforts at Local, National, and International Levels

The "War on Drugs" emphasis on interdiction and punishment has failed to reduce the supply of illicit drugs or reduce problems of drug abuse (6,36,1). Since 1981, the federal government has spent approximately $150 billion to reduce international drug trafficking without success (36,37,38). These punitive efforts also: (a) create friction with other countries, (b) contribute to political and economic instability in these other countries, and (c) reduce the funding available for prevention and treatment (39). Given these realities and the aforementioned negative outcomes of the War on Drugs, current priorities for combating drug abuse must change (40,41).

IV. POLICY RECOMMENDATIONS

The following recommendations are specific strategies that could be implemented in the near future. Drug addiction should be treated as a public health problem rather than a criminal justice problem, and the drug addict as a patient rather than a criminal. The broader social issues of poverty, racism, etc., will require long-term, broad efforts that are beyond the scope of this report. The National Association for Public Health Policy recommends the following harm-reduction actions:

- 1–Redistribute the majority of federal drug control moneys to prevention, treatment, and research.
- 2–Methadone maintenance should be available to all heroin addicts seeking such treatment.
- 3–Private physician-based methadone maintenance should be a generally available treatment for heroin addicts.
- 4–Heroin maintenance should be a generally available treatment for heroin addicts.
- 5–Every community where IDU drug use is endemic should institute a needle exchange.
- 6–The federal government should re-classify marijuana and heroin out of the Schedule 1 category and allow their prescription where medically appropriate.
- 7–Expand federal financial support beyond abstinence-only models of drug education and treatment.
- 8–Drug education programs in the schools and mass media must

minimize the use of scare tactics and honestly portray the realities of drug use and abuse.

- 9–Drug education should empower students to make informed judgments about the use and abuse of drugs.
- 10–America must learn to accept the fact that the core of its drug problem is internal demand and the social and personal factors that contribute to that demand. Blaming other countries is inappropriate. Foreign interdiction strategies and pressure on other governments should be sharply curtailed.
- 11–Reasonable sentencing discretion should be returned to judges by repealing mandatory minimum sentences for drug offenses.
- 12–Reconsider the usefulness of criminal penalties for the possession or use of marijuana.
- 13–Establish an objective commission, empowered by the President and Congress to recommend revision of the drug laws of the United States to reduce the harm caused by our current policies.

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